

Transitioning Adolescents with HIV to Adult Care: Outcomes From a Prospective Multi-Site Study

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Abstract:

Purpose: Youth (ages 13–29) living with HIV (YLHIV) account for nearly one-third of new HIV infections, face significant barriers to care engagement, and only 6% are virally suppressed. Healthcare transition (HCT) from pediatric/adolescent to adult-oriented care can be especially disruptive. Retrospective single-center studies indicate only half of youth remain engaged in care one-year post-HCT but no work prospectively examines HIV-related HCT. Accordingly, we examined HCT across 14 Adolescent Medicine Trials Network (ATN) clinical sites.

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Article:

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Methods: This prospective study collected self-report ACASI data (i.e., demographics, behaviors) and abstracted electronic medical record data from 135 behaviorally infected YLHIV (all eligible for transition by individual site criteria) at baseline and nine month follow-up. Successful HCT was defined as having at least one adult HIV clinic appointment by follow-up. Youth were primarily male (76.3%), Black (77.8%), and averaged 24 years old (range 21–24). Descriptive and multilevel model analyses were conducted using SPSS and Mplus. Data also included 58 interviews with staff (e.g., physicians, nurses, social workers) at adolescent (n = 28)

and adult (n = 30) clinics. Interviews were analyzed using the constant comparative method and guided by the American Academy of Pediatrics(AAP) HCT guidelines.

Results: Only 39% of YLHIV successfully transitioned within 9 months. In quantitative analyses, both individual- and clinic-level factors were relevant. Individual: YLHIV without healthcare insurance were significantly more likely to successfully transition compared to those with private insurance (EST = 1.24, OR = 3.5, $p = .02$). Clinic: Qualitative analysis showed that many clinics lacked formal transition protocols (AAP Guideline #1). Adolescent clinics that provided information and support about adult care options were more likely to successfully transition YLHIV (EST = .86, SE = .40, $p = .027$); these clinics reported responsibility for preparing youth for transition (AAP Guideline #2), (e.g., “[Youth] need so much more education regarding the service system... Because they don't know how to call for a refill, how to do all those things.”). More broadly, clinic staff worked closely to create connections between adolescents and adult clinics (AAP Guideline #3) to facilitate successful HCT (e.g., adult providers conducting initial visits in the adolescent clinic) and discussed the need to evaluate the transition process (AAP Guideline #4) (e.g., staff identified necessary components [e.g., adolescent-adult inter-clinic data sharing and communication] for assessing outcomes [e.g., appointment adherence, viral suppression]).

Conclusions: This study highlights the complex set of individual and clinic factors associated with HCT. We found that many YLHIV did not successfully transition: some patients may have returned to care in the adolescent clinic but others were lost to care. Also, insurance status is important but in unexpected ways; this requires further examination. Formal, proactive transition preparation—corresponding to current AAP recommendations—was empirically demonstrated to improve successful transition. Results suggest that adolescent and adult clinic involvement is essential to provide coordinated care, thus highlighting the importance of cultivating inter-clinic connections (e.g., communication and data sharing) to reduce service fragmentation and support YLHIV. Addressing these key factors is essential for developing streamlined, comprehensive, and context-specific transition protocols to support continuous care engagement for YLHIV.

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